BHSF Form 2-BCC
Issued 04/06

Renewal Due: _____
CSLD/WKR: _____

Medicaid Renewal Form

for the Breast and Cervical Cancer Program

You have received this form to help us decide if you can continue to get Medicaid through the Breast and Cervical Cancer Program. If you do not fill out and return this form, your health care coverage may end. When we get your filled out and signed form with the needed proofs (to verify what you have told us), we will send you a letter to let you know if you are still eligible.

Renewing Medicaid coverage is easy.

1. **Fill out** this form and **sign** it.
2. **Get together** the needed proofs. The things we need are shown with a picture of a mailbox (📪).
3. **Mail** the form and needed proofs to your worker at the local parish Medicaid office using the envelope that came with this form. You do not need a stamp. You may **fax** it.

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (list)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (list)* _____

1. Tell us about yourself (the person who gets Medicaid).

Name (First, Middle Initial, Maiden, Last)_____

Social Security Number_____ Date of Birth_____Parish_____

Mailing Address _____ City _____State____ Zip ____

Home Address (if different)_____City _____State___ Zip ____

Home Phone Number (_____) _____Cell Phone (_____) _____

Work Phone (_____) _____ Best Day or Time to Call_____

E-mail Address_____

2. Are you still being treated for breast and/or cervical cancer? ❑ Yes ❑ No

📪 *If **yes**, send us a statement from the doctor that is treating you about your continuing need for treatment and how much longer the treatment will last.*

3. Do you have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 4

📪 *Send us a copy of the front and back of all insurance cards. If insurance is through a job, we may be able to help pay the premiums.* If you need more space, use another sheet of paper.

Insurance Company Name _____

Insurance Company Address _____

Policy Number _____Group Number_____

Is breast and/or cervical cancer covered? ❑ Yes ❑ No Is the insurance through a job? ❑ Yes ❑ No

If you need help with this form, call your local Medicaid office or 1-888-342-6207 (TTY 1-800-220-5404). The call is free.

4. Does anyone live with you? ❑ Yes – Fill Out Below ❑ No – Go to Question 5

If more space is needed, use another sheet of paper. *Social Security numbers do not have to be given. They will only be used to verify income.*

Name (First, Middle Initial, Last)	**Social Security Number**	**Date of Birth** (Month, Day, Year)	**Relationship to You**
			❑ spouse ❑ child ❑ other (tell us)_____
			❑ spouse ❑ child ❑ other (tell us)_____
			❑ spouse ❑ child ❑ other (tell us)_____
			❑ spouse ❑ child ❑ other (tell us)_____

5. Is anyone working? ❑ Yes – Fill Out Below ❑ No – Go to Question 6

*Send copies of **all pay check stubs** or other proof of earnings for the **last month.** If self employed, send copies of the most recent federal tax form with **all** schedule attachments, or other proof if you do not have tax forms.*

Name of the Person Working	**Employer Name, Address, and Phone Number OR Self-Employment Information**	**Amount Paid Per Hour**	**Number of Hours Worked Per Week**	**How often paid?**	**Is health insurance offered?**
		$		❑ weekly ❑ every 2 weeks ❑ once per month ❑ twice per month ❑ other (tell us) _____	❑ Yes ❑ No
		$		❑ weekly ❑ every 2 weeks ❑ once per month ❑ twice per month ❑ other (tell us) _____	❑ Yes ❑ No

If you have questions, call your local Medicaid office or 1-888-342-6207 (TTY 1-800-220-5404). The call is free.

6. Does anyone get any money like Social Security, SSI, Veteran's Benefits, worker's comp, retirement, child support, rent from property, Unemployment, money from friends and relatives, or any other type of income? ❑ Yes – Fill Out Below ❑ No – Sign Form Below

*Send proof of the income. You **do not** have to send proof of Social Security, SSI or Unemployment.*

Income Type	Who pays this money? (Name, Address, & Phone)	Who gets this money?	How much?	How often?
			$	❑ once per month ❑ other (tell us) _____
			$	❑ once per month ❑ other (tell us) _____
			$	❑ once per month ❑ other (tell us) _____

Sign Your Name Here:_____Date _____

Please use the envelope that came with this form to mail back the form and proofs to your local Medicaid office. Thank you for your time in filling out this form.

If someone from Medicaid filled out this form for you, then they will sign below.

_____Date_____

✓ Before you send this form, please check the following:

- ☐ **I answered all questions and filled out all parts of this renewal form.**
- ☐ **I am sending a statement from my doctor about my treatment.**
- ☐ **I am sending proof of income for all persons listed on this form.**
- ☐ **I am sending a copy of both sides of all health insurance cards.**
- ☐ **I signed and dated the form on this page.**